South Dakota Health Care Solutions Coalition

Meeting Notes 12/16/2015

Attendees: Kim Malsam-Rysdon, Lynne Valenti, Brenda Tidball-Zeltinger, Jerilyn Church, Dr. Mary Carpenter, Terry Dosch, Janet Jessup, Kathaleen Bad Moccasin, Monica Huber, Richard Huff, Jason Dilges, Rep. Don Haggar, Sen. Deb Soholt, Sara DeCoteau, Scott Duke, Jennifer Stalley, Deb Fischer-Clemens, Sen. Bernie Hunhoff, Sen. Corey Brown, Sunny Columbe, John Vetsch on behalf of Mike Diedrich, Sen. Deb Peters, Rep. Spencer Hawley, Mark East, Sonia Weston

Welcome and Introductions

Don Novo from HMA opened the meeting, and the Coalition members introduced themselves.

Review of December 3 Meeting Minutes

The group was asked to review the minutes from the last meeting at (http://boardsandcommissions.sd.gov/Template.aspx?id=145) and submit any changes, revisions, or comments to Kelsey Smith at Kelsey.Smith@state.sd.us.

All three subcommittees met on December 3 and 4.

The New Services Subcommittee Update:

The New Services Subcommittee discussed the following topics during their December 3rd meeting:

- Tribal Community Health Representative (CHR) survey and development of a working definition for a CHW/CHR program
- Development of a working definition of the Community Health Representative (CHR) Services that would be provided if implemented in South Dakota by Medicaid, including:
    - Service definitions
    - Targeted populations
    - Qualifications
    - The engagement of CHRs as a member of the care team
- Determined that Medication Therapy Management (MTM) should be leveraged through the Health Homes Program so there is no specific recommendation in this area.
- Development of Subcommittee recommendations for the December 16th Coalition meeting

Increasing Access Subcommittee Update:

The Access Subcommittee discussed the following topics at their December 3rd meeting:

- IHS CEO survey and additional survey questions to add to the survey
- IHS Services solicitation approach for area-wide, TeleHealth services, and the need for the contract to identify all TeleHealth specialty services that an IHS facility may need to contract for with non-IHS providers
- Development of Subcommittee recommendations for the December 16th Coalition meeting

Behavioral Health Subcommittee Update:

The Behavioral Health Subcommittee discussed the following topics at their December 4th meeting:

- Presentation on Medicaid program Substance Abuse services
- Great Plains Tribal Chairmen's Health Board presentation of their Access to Recovery program
- Capacity for IHS participation in the Medicaid Behavioral Health Health Homes program
- Overview of Tele-Psychiatry and use in the Medicaid program
- Development of Subcommittee recommendations for the December 16th Coalition meeting

Don reminded the Coalition members that the Subcommittee minutes provide summaries on each of the Subcommittee workgroups meetings and are available on the boards and commissions website at (http://boardsandcommissions.sd.gov/Template.aspx?id=145).

Update on discussion with CMS and IHS

The State has had several conversations with CMS about the White Paper and the Coalition's responses, as well as other stakeholder responses. CMS has not provided an estimated release date for the final CMS guidance, but recognizes the importance of being thorough and making changes that will support South Dakota's plan to increase access to services and leverage funding in the existing budget to support Medicaid expansion. Those discussions have also centered on specific support for IHS and Tribal health programs to maximize the opportunity these policy changes present. South Dakota asked for technical assistance from CMS to work through some of the specific issues unique to the State. There needs to be strong coordination with IHS, since most of the care is delivered through the IHS system, rather than Tribal providers. The Great Plains Tribal Chairmen's Health Board also requested CMS technical assistance. The big concerns with the changes are related to legal authorities and operationalizing the changes. The State and Tribes are having frequent conversations, as well, to work through many of these challenges.

Governor Daugaard gave his budget address last week, which included his plan to expand Medicaid if the State, IHS, and the Tribes can create enough savings through the CMS FMAP changes to cover the costs. He has noted that he will not support expansion without support from the Tribes and the Legislature. The State has used very conservative numbers to estimate the cost of expansion. The Governor has so far presented his proposal in Rapid City, Sioux Falls, and Aberdeen and will be in Pierre at the end of December, and will present the proposed budget to at least two Tribes.

Scott Duke noted that they have had good feedback from stakeholders about the Governor's proposal and appreciated the transparency of the process and information. Sen. Soholt went to the Sioux Falls legislator session, where the attending legislators appreciated the Governor's explanation. There are still many questions, but people were pleased to get the information they could understand and evaluate. Deb Fischer-Clemens noted that people need to understand how many people this could potentially impact and benefit, and more patient-specific information about how Medicaid works with IHS and Tribes. Keeping an open mind about the process and how it can work is a very important message from Coalition members.

Coalition Recommendations

The group discussed and adopted the following recommendations and clarified that any new services recommended would be paid for with funding made available through the CMS policy change to the degree there is funding that exceeds the cost of expansion in 2021.

Recommendation 1: Increase use of Tele-Health services to support emergency departments in IHS service units and support increased access to Primary and Specialty Care Consultation and Treatment.

- Eagle Butte and Rosebud were identified as the priority locations to pilot e-emergency services.
- IHS will implement an area wide standardized contracting approach to providing Tele-Health services at IHS facilities.
    - IHS will develop a menu of services all IHS locations can pick from to support access to Primary and Specialty Care Consults and Treatment within IHS facilities.
    - IHS will publish a request for proposals, and multiple providers can be selected to support these services.
    - IHS will gather necesssary information to formulate area wide service contracts. Individual IHS/Tribal Health Organizations could choose the specialy care services they want based on their populations and communities.
- Expand use of Tele-Health to support Prenatal care for high risk pregnant women. The Wagner IHS Service Unit will pilot this service using the CareSpan service to link providers with high risk patients.
- Explore the ability to expand the use of Tele-Health in Behavioral Health and Substance Abuse services through consideration of existing providers and services eligible for Medicaid reimbursement.

  The group had discussions regarding the process and next steps relative to the IHS solicitation. Carol Diaz clarified that IHS is finalizing the scope of work and will be collecting some additional information from providers over the next few weeks to finalize the Tele-Health equipment needs and other details. IHS has visits to providers set up this week to help gather necessary information. Once the scope of work for the solicitation is finalized, IHS will move forward with the solicitation and look to award contracts.

Recommendation 2: Develop a formal Community Health Worker/Community Health Representative program within Medicaid.

- Some individuals need assitance to navigate the formal healthcare system and address barriers to accessing healthcare. Community Health Workers (CHWs) are trusted members of the community that help individuals access healthcare services.
- Services include health promotion and health education, arranging for transportation (as opposed to providing transportation), disease-specific education, specific direct client services (e.g., wound care, medication support, vital signs) assisting individuals in navigating the health care system, and connecting individuals to other community services and supports.
- Services are physician ordered and provided face-to-face in the individual's home or community. Services could be referred by a physician, physician assistant, behavioral health provider, etc.

CHWs work under the supervision of licensed health care professionals including physicians, physician assistants, and nurse practitioners.

- The target population are individuals needing assistance to implement their care plan and would support individuals transitioning from hopsital or inpatient treatment, and supporting pregnant women who need access to Prenatal or Postpartum care.
- Individuals served through the Medicaid Health Home program would receive these serves through the core service provision. Individuals not served through Health Homes who otherwise qualify would be eligible for CHW services through the Medicaid State Plan.
- The implementation of this will depend on financial impact.

Brenda Tidball-Zeltinger outlined next steps in this area to include evaluating the mechanism in the Medicaid state plan to implement this service and to develop an approach operationalizing the recommendations. DSS will work to identify the appropriate State Plan authority and will gather provider and other stakeholder feedback about implementation and analyze the fiscal impact.

Recommendation 3: Expand support for Prenatal and Postpartum care to support healthy birth outcomes.

- Ensure that Community Health Worker services incorporate services for pregnant women. This recommendation integrates the recommendation to develop a CHW/CHR program in Medicaid.
- Expanding use of Tele-Health to support specialty prenatal care for high risk pregnant women. The Wagner IHS service unit will pilot this service using the CareSpan service to link providers with high risk patients.

Recommendation 4: Expand capacity for Mental Health and Chemical Dependency Services through Indian Health Service and Tribal Programs

- Develop IHS Behavioral Health Health Homes. Almost 1/3 of the individuals in the Medicaid Health Home program are served by IHS primary care health homes. Leveraging this infrastructure and developing partnerships with tribal and community behavioral health programs could be used to develop Behavioral Health Health Homes.
- Explore ability for IHS and Tribes to develop a Community Mental Health Center (CMHC) model. Provide support for technical assistance for IHS and Tribal programs to better understand CMHC model and requirements.
- Medicaid eligible services provided by IHS or Tribal programs are eligible for 100% federal match today. Assist IHS and Tribal programs to expand substance abuse services through Medicaid.

The Community Mental Health Centers and Substance Abuse providers also offered support to assist IHS and Tribes in developing CMHC and substance abuse services.

Recommendation 5: Expand Medicaid eligible providers of Behavioral Health and Substance Abuse Treatment Services.

- Add Licensed Marriage and Family Therapists and Licensed Professional Counselors under a formal supervision plan from the Board of Counselor Examiners to provide services through the Medicaid State Plan. The implementation of this will depend on financial impact.
- Substance Abuse Services should be consistent with the current and expansion population. Analyze the potential impact of the use of Medicaid funds for current services to determine the scope of services.

Discussion about this recommendation centered on the positive impact of expanding Behavioral Health Services. Also, the Coalition supported the provision of consistent services for the existing and expansion population. This approach will ensure individuals have access to services regardless of funding source and be more efficient for the state and providers to administer.

Recommendation 6: Add evidence-based Behavioral Health services and supports for children and families.

- Add Functional Family Therapy (FFT) as a Medicaid state plan service.
- Consider feasibility of day hospital stays and school-based services, as part of the full continuum of services for children and youth (as well as adults), depending on resources available.

The discussion focused on the benefit of leveraging Medicaid for FFT for those youth that are Medicaid eligible.

Draft Interim Coalition Report and continued Coalition engagement:

The group discussed how to ensure continued Coalition engagement as more information becomes available from CMS through the final CMS State Health Official or SHO letter. Coalition members will receive a draft interim report by the end of December. The Coalition members will review and then discuss the interim report at the January 6 meeting. The interim report will address the recommendations brought forward to the Coalition from the three Subcommittees. This report will outline the action items necessary to prepare for implementation of Subcommittee recommendations. These action items include:

- IHS implementation of an area wide standardized contracting approach to providing Tele-Health services at IHS facilities
- Feasibility to expand the use of Tele-Health in behavioral health and substance abuse services through consideration of existing providers and services eligible for Medicaid reimbursement.
- DSS evaluation of Medicaid State Plan authorities to implement Community Health Worker/Representative (CHW/CHR) program
- Development of an approach for operationalizing the CHW/CHR recommendations, including program financial impact.
- Feasibility of IHS and Tribes to develop a Community Mental Health Center (CMHC) model.
- Provide Technical Assistance to IHS and Tribal programs to better understand CMHC model and requirements.

- Provide Technical Assistance to IHS and Tribal providers to ensure their capacity to bill for all Medicaid eligible services currently eligible for 100% FMAP, such as transportation.
- Identification of the Federal authorities, (State Plan and FMAP policy changes) and both State and IHS/Tribal timeframes required to implement program changes.

After the January 6 meeting, the group concurred that bi-weekly conference calls will be scheduled to discuss the impact of the final CMS guidance and to communicate progress about various recommendations. Consistent with the Coalition process to date, these calls will include minutes/notes, so anyone not able to participate can remain engaged in the Coalition activities and discussions. It would be helpful to include how the information is being processed by the Legislature (as those discussions will be happening simultaneously). Staff will also provide support for Coalition members to communicate the information to their constituents.

Jerilyn Church noted that the Tribal providers have a lot of concerns about being able to logistically meet the requirements and leveraging Medicaid in a way that would be meaningful. The ACA and Health Reform are new policies, and this requires a review of existing policy to identify what needs to change. The Tribes want to ensure they have the capacity and capability to successfully administer changes, such as third-party billing.

Closing Remarks

Kim Malsam-Rysdon and Jerilyn Church thanked the Coalition members for their commitment to this process and the great ideas and discussion that they have brought. In addition to developing recommendations to increase access to health care and behavioral health services, the Coalition has helped build relationships that will create a long-term benefit for the State, IHS, the Tribes and other stakeholders.

Next Steps:

- IHS will provide the Coalition with feedback on the three bullet points (2,3,4) under Recommendation One.
- The interim report of the Coalition will be provided for review before the January 6, 2016 meeting.

Next Meeting

Wednesday, January 6, 2016, 1 – 3 p.m. Central Time, Ramkota Gallery B

REMINDER - All the materials from the Coalition and Subcommittees are available online at *boardsandcommissions.sd.gov*